

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No.

3107

989

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis		c. LENGTH OF STAY (in this place) 25 Yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1012 No. Jefferson Ave.				d. STREET ADDRESS (If rural, give location) 1012, No. Jefferson			
3. NAME OF DECEASED (Type or Print) John Wesley Palmer				4. DATE OF DEATH (Month) (Day) (Year) 1-28-49			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 12-25-1892		9. AGE (in years last birthday) 56	10. IF UNDER 1 YEAR Months I 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Public Library		11. BIRTHPLACE (State or foreign country) Columbia, Murry Co. Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Forest Palmer		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Myrtle Palmer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS 1012 No. Jefferson			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION Cardio-valvular disease  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) -  DUE TO (c) -  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  19a. DATE OF OPERATION None				INTERVAL BETWEEN ONSET AND DEATH unobtainable	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) -		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21c. (CITY, TOWN, OR TOWNSHIP) -		21d. (COUNTY) -	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) -		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -			
22. I hereby certify that I attended the deceased from 12-30-1948, to 1-25-1949, that I last saw the deceased alive on 1-25-1949, and that death occurred at 9:30 P.M., from the causes and on the date stated above.							
23a. SIGNATURE Drs. Wolff D.H.D.				23b. ADDRESS 1418 Franklin		23c. DATE SIGNED 1-29-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-5th-49		24c. NAME OF CEMETERY OR CREMATORY Green Wood Cem.		24d. LOCATION (City, town, or county) (State) ST. Louis. M.	
DATE REC'D BY LOCAL REG. FEB 1 1949		REGISTRAR'S SIGNATURE J.B. Sasator		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hannon		ADDRESS 2829, Washington, B.	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

Licensed Embalmer No. 444

P. O. Address 2829 Washington

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.